

NOTICE OF ADMINISTRATIVE ACTION

TYPE OF ACTION: ORDER SUMMARILY SUSPENDING LICENSE TO OPERATE AN ADULT CARE HOME

ISSUED TO: Anita Jefferson Jones, Licensee
Concord Retirement Center
166 Union Street
Concord, NC 28025
HAL #013-028

Pursuant to N.C. Gen. Stat. ' ' 131D-2(b)(3) and 150B-3(c) , the North Carolina Department of Health and Human Services, Division of Facility Services, Adult Care Licensure Section hereby summarily suspends the license issued to Anita Jefferson Jones to operate an adult care home known as Concord Retirement Center, HAL #013-028, for a period of five years, effective upon receipt of this order. This action is based on the agency's finding that conditions at the adult care home present an imminent danger to the health and safety of certain residents at the home. Therefore, emergency action must be taken. You must close by 5:00 p.m. on the day on which this order is delivered or by 5:00 p.m. on the day on which the last resident is discharged from Concord Retirement Center, whichever is later. The Cabarrus County Department of Social Services will assist you in relocating the residents of the facility.

BASIS FOR ACTION

On July 20-22 and 27, 2005, the adult home specialist with the Cabarrus County Department of Social Services and staff of the Adult Care Licensure Section surveyed Concord Retirement Center. Additionally, on July 19, 2005, a representative of the Construction Section inspected the facility. As a result of the surveys and inspections, the Section substantiated violations of N.C. Gen. Stat. ' ' 131D-4.4 and -21(1), (2) and (4) and 10A NCAC 13F .0305, -.0403, -.0504, -.0601, -.0703, -.0802, -.0901, -.0903, -.0904, -.0909, and -.1001 in the areas of minimum safety requirements, resident rights, physical environment, evacuation plans, staffing competency, facility management, TB testing and level of care for residents, resident care planning, personal care and supervision, health care, licensed health professional support, nutrition and food services and drug management. The basis for the substantiation of the violations are set forth in Attachments A, which are attached hereto and incorporated herein by reference. You will be provided a copy of the statement of deficiencies by mail.

The failure to maintain the minimum safety requirements and physical environment of the facility places the residents' health and safety in imminent danger. For example, when the fire alarm system is not maintained in its proper working condition, the facility's ability to timely react to a fire condition is compromised, as well as the residents' safety. Failure to provide required air movement for residents during extreme hot temperatures places the residents' health at risk. Also, failure to have a working sink at the medication administration area reduces the likelihood that proper hand washing is performed by medication staff who are administering medicine to residents

and may compromise aseptic conditions placing the residents' health at risk. When the back door alarm fails to function, as required by rule, disoriented residents are in danger of elopement without detection by the facility. If a resident elopes, the resident's health and safety is placed in imminent danger. All of the violations of the minimum safety requirements and physical environment are discussed more fully in Attachment A.

The failure of the facility to assure that residents receive care and services which were adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations and were free of mental and physical abuse, neglect, and exploitation places the residents' health and safety in imminent danger. For example, there have been allegations and reports of illegal drug use in the facility, buying and selling of drugs by both staff and residents and alcohol use by staff and residents. The use of alcohol and illegal drugs by staff impairs judgment and performing tasks, which place residents' safety and welfare at risk. Residents with underlying health and mental conditions combined with the use of alcohol and illegal substances place the residents' health, safety and welfare at risk. When the facility fails to timely change a resident with a diagnosis of paraplegia, the resident's health is placed in imminent danger. During the July 27, 2005 survey, the facility temperature ranged from 84 to 92 degrees F. The staff was not observed to offer increased fluids, cool cloths or any measures to assist residents' tolerance of the hot temperatures. Failure to intervene with increased temperatures place the residents' health and safety in imminent danger.

The failure to assure that residents are treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy places the residents' health and safety in imminent danger. When a facility takes a resident to a medical appointment and leaves him there for an extended period of time beyond the appointment without supervision, the resident's health and safety are at risk. When care is not promptly provided to dependent care residents, the residents' health and safety are placed at risk. All of the violations of the residents' rights are discussed more fully in Attachment A.

When a facility fails to conduct quarterly fire drills and fire plan for each shift, all of the residents' health and safety are placed in imminent danger. Although the Division of Facility Services and the Cabarrus County Department of Social Services had identified this problem during the survey on 07/19/05 and 07/20-07/22/05, no fire drills or additional training had been done with staff since that time. During the inspection by Construction Section, facility staff was not knowledgeable of how to pull the alarm or reset the fire alarm. All the violations related to evacuation plan are discussed more fully in Attachment A.

The failure to properly train staff places the residents' health and safety in imminent danger. For three of seven sampled staff administering medication, no documentation existed that they had been properly trained. Also, there was no documentation, which indicated that non-licensed staff had been properly trained with respect to transferring and lifting a resident with a Hoyer lift. All the violations related to qualifications of staff and staff competency are discussed more fully in Attachment A.

The failure of the facility to assure that the administrator demonstrates responsibility for the total operation of the facility and compliance with the law and rules places the residents' health and

safety at risk. During the July 20-22, 2005 survey, staff indicated that rarely saw either the administrator or administrator-in-charge. When contacted by phone on July 20, 2005 and notified on the on-going survey, the licensee responded, "there's no way we can come down today, my mom (the administrator) has an appointment today at 2:15PM." When the survey team asked the facility manager if she felt capable of handling the current situation regarding the temperature readings of the facility and APS involvement, she responded "no". All the violations related to management of the facility plan are discussed more fully in Attachment A.

The facility failed to assure that upon admission, 2 of 6 residents sampled had been tested for tuberculosis disease, as required by rule. Failure to test a resident for TB places all residents at risk for contracting the disease and accordingly, all residents' health is placed in imminent danger. During the survey, it was determined that a resident in the facility had an FL-2, which indicated that he needed to be in skilled level of care. Failure to obtain proper placement of a resident places that resident's health and safety in imminent danger. All the violations related to TB testing and level of care are discussed more fully in Attachment A.

The failure of the facility to assure for the personal care and supervision of the residents places the residents' health and safety in imminent danger. For example, semi-ambulatory and non-ambulatory residents were observed without access to functioning signaling devices. When a resident's mobility is limited, a signaling device is necessary in order for the resident to call for help or assistance. Also, a resident was observed smoking alone in his room. On July 27, 2005, a resident with no to limited mobility in the lower extremities and limited mobility in the upper extremities smoked in his bed. After staff lit the cigarette, they left the resident's room. All violations related to personal care and supervision are discussed fully in Attachment A.

The failure of the facility to assure the participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care places the residents' health and safety in imminent danger. Medically involved residents had not received a thorough on-site review, evaluation and care planning as required by the rule. All violations related to licensed professional support are discussed fully in Attachment A.

The failure to provide adequate food services as required by the rules places the residents' health and safety in imminent danger on a daily basis. The minimum dietary requirements, as well as physician prescribed modified diet, address the dietary and overall health needs of the residents. Residents' health can be adversely affected when the dietary requirements and diet orders are not followed. For example, the kitchen staff did not have therapeutic menus, which matched the physician-ordered therapeutic diets for three residents. Also, residents were not provided one cup (8) ounces of pasteurized milk at least twice a day and water was not served at each meal, in addition to other beverages, as required by rule. All violations related to nutrition and food service are discussed fully in Attachment A.

The failure of the facility to ensure the development and implementation of written policies and procedures for the ordering, receiving, storage, discontinuation, disposition and administration of medications, including the self-administration of medications places the residents' health and safety in imminent danger. During the survey of July 20-22, 2005, staff indicated that they were not aware of any written policies and procedures for medication administration. Problems were noted in

the areas of self-administration, storage, labeling, documentation on the medication administration records, controlled drugs, pre-pouring and medication administration. Medications were stored in unlocked areas. The facility procedures for transcription of orders and medication administration were not safe practices, thereby placing the residents at risk for a medication error. All violations related to medication administration policies are discussed fully in Attachment A.

The failure of the facility to assure that staff administered medications, prescription and non-prescription, and treatments according to orders by a licensed prescribing practitioner places the residents' health and safety in imminent danger. During the July 20-22, 2005 survey, medications were not administered, as prescribed, to six residents. Other examples of medication errors are fully discussed in Attachment A.

The failure of the facility to ensure that the care, safety, and services necessary to enable the residents to attain and maintain the highest practicable level of physical, emotional, and social well-being places the residents' health and safety in imminent danger. During the July 20-22, 2005 survey, it was determined that five residents who needed health care coordination did not receive it. During the July 27, 2005 survey, it was observed that the health care coordination needs one of the afore-mentioned five residents were still unmet. A thorough description of the resident's needs and conditions as well as all the violations related to minimum safety requirements are discussed fully in Attachment A.

PROCEDURE FOR APPEAL

You have the right to contest this summary suspension of license to operate an adult care home by filing a petition for contested case hearing with the Office of Administrative Hearings pursuant to N.C. Gen. Stat. ' 150B-23, et seq. The petition for contested case hearing must be filed with the Office of Administrative Hearings within twenty (20) days of the mailing of this notice. If you file a petition for contested case hearing with the Office of Administrative Hearings, you will receive a notice of the contested case proceeding from the Office of Administrative Hearings. If you have any questions concerning the contested case proceeding, you should contact the Office of Administrative Hearings at 424 North Blount Street, Raleigh, North Carolina (919) 733-2698. Correspondence should be addressed to the Office of Administrative Hearings, P.O. Drawer 27447, Raleigh, North Carolina 27611-7447.

Date

Barbara Ryan, Chief of Adult Care Licensure Section
Division of Facility Services
N.C. Department of Human Resources

STATE OF NORTH CAROLINA

COUNTY OF CABARRUS

The Notice of Administrative Action, dated July ____, 2005, was delivered in person by
_____, Consultant with the Adult Care Licensure Section on _____.

Signature of Recipient

Signature of Section Representative

Date